Kansas Department of Health and Environment

Long Term Care Program

FACT SHEET

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In this issue....

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L PLEASE ROUTE THIS *Fact Sheet* TO NURSING STAFF AND OTHER INTERESTED PARTIES IN YOUR FACILITY. THIS PUBLICATION MAY BE COPIED OR ACCESSED THROUGH THE INTERNET ADDRESS ABOVE.

The Long Term Care Program Fact Sheet is a newsletter published by the Kansas Department of Health and Environment and sent quarterly to all nursing facilities, long term care units in hospitals, critical access hospitals, intermediate care facilities for the mentally retarded and nursing facilities for mental health. This newsletter provides important up-to-date information concerning the nursing facility industry.

Involuntary Discharge From an Adult Care Home

Involuntarily discharging a resident should be a rare occurrence. Federal and state regulations for involuntary discharge are very similar. Facilities must ensure that the reason for the involuntary discharge meets regulatory requirements. Residents may be involuntarily discharged if the following conditions are met:

1. The resident's physician has documented in the resident's clinical record that the resident's welfare and the resident's needs cannot be met by the adult care home.

   The case must be made that the resident is in need of services which the facility cannot provide.

2. The resident's physician has documented in the resident's clinical record that the resident's health has sufficiently improved and the resident no longer needs the services provided by the adult care home.

3. A physician has documented in the resident's record that discharge or transfer of the resident is necessary because the health or safety of other individuals in the adult care home is endangered.

4. The resident has failed after appropriate notice to pay the rates and charges due the adult care home.

Documentation should be available in the business records that the facility has made an effort to collect the monies owed.

Residents in a Medicaid certified nursing facility have the right to appeal an involuntary discharge to the Department of Administration. Information on the appeals process can be found in the Adult Care Home Provider Manual in the Benefits & Limitations section beginning on page 8-20. This manual is published by Blue Cross/Blue Shield for the Department on Aging.

All residents have the right to report an involuntary discharge to the KDHE complaint line for review.

Hospice Referrals

Medicare beneficiaries residing in certified nursing facilities can elect to receive the Medicare hospice benefit. It is the responsibility of the facility to ensure that the resident and/or the resident's legal representative are provided the opportunity to select the hospice of their choice to provide that service. Section 1802 of the Social Security Act gives each Medicare beneficiary the right to obtain health services from any institution...(hospice)... The resident has the right to choose the agency. It is the responsibility of the facility to inform the resident of the hospices which operate within the area the facility is located.

If one of the payment sources for the resident's stay in the nursing facility is Medicaid, the facility must have an agreement with the hospice for the professional management of hospice services. The nursing facility can determine what hospice or hospices it wants to enter into an agreement with to serve Medicaid recipients. Residents must be informed at admission if there is a limitation on the hospice organizations in the area available to Medicaid residents of the facility. The intent is that a resident can then make an informed decision related to which nursing facility will meet their needs. Nursing facilities must arrange for hospice care if requested by a resident.

Section 2082 of the **State Operations Manual** (SOM) is the only place where hospice services in a nursing facility is discussed. The manual states that a "patient's home is where he or she resides". A hospice may furnish routine or continuous home care to a Medicare beneficiary who resides in a skilled nursing facility, a nursing facility, an intermediate care facility for the mentally retarded, or any residence or facility not certified by Medicare or Medicaid. The SOM further states that the hospice assumes the full responsibility for professional management of the individual's hospice care in accordance with the hospice Conditions of Participation... The skilled nursing and nursing facility (SNF/NF) Conditions of Participation are applicable to all residents in a SNF/NF facility. Neither the statute nor the regulations setting out SNF/NF requirements exempts hospice patients from those regulations. Therefore, residents who choose to elect the hospice benefit while residing in a SNF/NF have the right to the same rights and services as all other residents in the facility. The hospice and the SNF/NF must work together in the development of a coordinated plan of care. The plan of care must identify the services provided by the SNF/NF and those provided by the hospice.

Residents who reside in licensed only nursing facilities have the right to elect any hospice servicing the area in which the facility is located. It is the responsibility of the nursing facility and the hospice to develop a joint plan of treatment which meets the needs of the resident.

Semi-Annual Report

Enclosed with this Fact Sheet is the Long Term Care Semi-Annual Report for the 6 month reporting period of January 1 through May 31, 2000. THE DEADLINE FOR FILING THIS REPORT IS August 15, 2000. This report shall be filed

with the Bureau of Health Facilities, Kansas Department of Health and Environment. All **NURSING FACILITIES, ASSISTED LIVING FACILITIES, RESIDENTIAL HEALTH CARE FACILITIES, NURSING FACILITIES FOR MENTAL HEALTH, and INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED** are required to complete this report by indicating resident and employee data for the six month period January 1- May 31, 2000. If you have any questions, please contact Patricia Maben, Director, Long Term Care Program, (785) 296-1246.

Verification of Licensure for Licensed Nurses

It is a good employment practice for facilities to confirm the licensure status of licensed nurses prior to employment. Employers can gain access to licensure data on the Internet though the Information Network of Kansas (INK). The Board of Nursing has announced that licensure data will be updated every Monday morning, with the exception of holidays and on the second working day prior to the end of each month. Currently INK charges $75 for the first year of service and $60 per year thereafter. In addition there is a 25¢ charge for access event.

Employers may request written verification of licensure. The Kansas Board of Nursing verification charges are as follows: five names or less - $2.00; six to ten names - $3.00; 11-15 names - $5.00; and more than 20 names, add $1.50 per five names.

Phone verification of a nurse's license is available on the last two working days of the month. There is no charge for phone verification.

For further information contact the Kansas Board of Nursing at 785-296-4929.

ANE Prevention Training

Last year the Kansas Association of Homes and Services for the Aging received a grant for a train the trainer program in the prevention of abuse, neglect and exploitation. Seventy individuals attended the training. A number of these individuals have indicated they would be willing to provide training in facilities other than their own. Contact Edith Stunkel, Director of Planning and Research at KAHSA for more information. 785-233-7443 ext. 223.

Immunization Records for Employees

There are no specific regulations for long term care facilities concerning immunization histories for employees. Based on documentation in the literature concerning nosocomial transmission, health care workers are at significant risk for acquiring and transmitting measles, mumps, rubella, hepatitis B, varicella, and influenza. Vaccination is strongly recommended to safeguard the health of workers, and to protect residents from becoming infected. Facilities are encouraged to formulate a comprehensive immunization policy for all health care workers.

An immunization record should be maintained for all employees reflecting documented proof of immunity to the diseases for which health care workers are at most risk. The immunization record should include all vaccinations administered, the date of administration, and the agency providing vaccination. Employees should be asked to provide documentation of their immunization history prior to employment.

Attached to this issue of the FACT SHEET is a listing of infectious diseases and recommendations for immunization.

New Reports on MDS Website

New reports are available on the MDS Submission Website. The reports were developed by the Health Care Financing Administration and were included in the state agency software update in May. Facilities are encouraged to use the reports with discretion.

Medicaid certified facilities must continue to use the Kansas Delinquent Report (Delinquents.pdf) to identify delinquent assessments.

Report of Analysis of Citations related to Falls

During the first quarter of 2000 twenty three skilled nursing/nursing facilities received citations related to resident falls. The following is a summary of the findings identified in the citations.

1. The number of incidents of falling experienced by a resident ranged from one to eighteen within a three month period. The two findings related to one fall were due to lack of care planning for a resident who had been identified to be at high risk for falls.

2. A large number of falls occurred when a resident was sitting on a toilet and staff left the resident unattended. In almost all of these incidents, the plan of care stated that the resident was to be supervised while on the toilet due to risk of falls.

3. Plan of care included the use of personal body alarm. Many of the findings indicated that the personal body alarms were not functioning and the facility did have a system to test the alarms. Nursing staff had not used the personal body alarm as indicated by the care plan. Care plans were not revised when the resident was found to remove the body alarm.

4. A number of findings indicated the facility policy and the resident's care plan were not followed related to use of gait belts during transfers.

5. Resident experienced repeated falls after the development of the care plan following admission. The plan of care was not revised when interventions obviously did not work.

6. MDS assessment indicated that two person transfers were used. The plan of care did not include the use of two person transfers and resident fell when only one person assisted with the transfer.

7. Restorative nursing activities related to increasing strength and balance were not included in the care plan.

8. Balance test documented on the MDS did not reflect the resident's functioning.

It is very important that the interdisciplinary team be involved in the development of a plan of care for residents at risk for falling. When the MDS indicates that the residents has a history of falls, unsteady gait and impaired sitting and standing balance the falls RAP must be completed to identify the causative factors. The plan of care should reflect how the staff will attempt to remediate these causative factors and reduce the likelihood of falls. Every fall cannot be prevented. However, it is the responsibility of the facility to develop a plan of care which reflects the needs of the resident identified in the assessment.

Credentialing Update

HOC Advisory Group: Partnership Success Stories

During the spring of 1999, Health Occupations Credentialing needed an avenue for informal discussion with credentialing stakeholders. The HOC Advisory Group was conceived to be a sounding board for concepts and changes HOC contemplated and customers wanted, as well as developing a partnership in the decision-making and implementation of such changes. This venue has provided an informal setting for sharing ideas and recommendations for HOC program enhancements. The mailing list includes representatives of KPNHAA, KAHSA, KHCA, KHCA (home health), KDOA, the Office of the LTC Ombudsman, educational institutions and others. Significant topics for this group include:

- ***Recertification for nurse aides and home health aides***. Assessment was that recertification did not hold much advantage to the agency, the industry or the aides at this point in time. Several proposals were constructed; these

are on file and available, should the issue resurface.

- ***Certified Physical Therapist Assistants and Registered Occupational Therapy Assistants bridge course*** (12 hours didactic, 12 hours clinical). Candidates complete the course and pass the state CNA test. The course is taught by a department approved nurse aide instructor. (Copies of the curriculum are available from Martha Ryan, 785-296-0058 or Mryan@kdhe.state.ks.us.)

- ***Automating the certification tests.*** After consideration, the group determined that the industry really wanted more frequent testing options. A "win-win" scenario: the structure of the test administration does not change, but employers may now opt to schedule an ***alternative test certification date*** by contacting HOC and following the steps outlined in policy. (Available by contacting Betty Domer, 785-296-1250 or Bdomer@kdhe.state.ks.us).

- ***Rewrite of the Certified Medication Aide curriculum and test.*** The Advisory Group recommended persons for the committees; there has been completion of a blueprint for the curriculum and commitment to rewrite the curriculum and tests by committee members.

- KAHSA and HOC collaborated in ***a full-day training session in Wichita for instructors of nurse aide courses***. KAHSA developed the program, HOC provided training needs from a survey of instructors (included the program brochure in the Update newsletter) and participated in a panel discussion.

- ***Criminal Background Checks Program and House Bill 2700***. A Report to the Legislature on the program operations was provided by KDHE during this past session. Staff identified several improvements and enhancements believed to be beneficial. Concurrently, the long term care industry proposed changes to the criminal background check law, KSA 39-970 and KSA 65-5117 (House Bill 2700). Core topics: broadened criminal history record information distribution (maintained by the Kansas Bureau of Investigation); KDHE providing results for all inquiries; a prescribed response time for inquiries; and, private contractors providing the service. HB 2700 represented an opinion the industry had not expressed during the deliberations of the original legislation; it also breached legal parameters which govern the criminal history record information. The statute is written to protect frail and elderly from individuals whose criminal conviction record identifies a serious "crime against persons." There is a specific list of crimes for which a person must not work in an adult care home or home health agency. The proposals under HB 2700 portended employers using the criminal records as an employment screening tool without identifying how hiring decisions could place the employer in legal jeopardy. This issue was identified during legislative hearings. The complicated legal and administrative issues prompted HOC to use the Advisory Group as a forum to facilitate some of the enhancements staff had identified, implement substantial changes within existing statutory language, and perhaps offer a proposal for future legislative consideration.

The Advisory Group has developed a history of creative problem-solving and improved understanding among its members. If anyone is interested in participating or receiving minutes from the meetings, please contact Lesa Bray at 785-296-1281 or Martha Ryan at 785-296-0058.

Automation of KNAR

HOC has put forth a ***proposal*** to the KDHE Division of Information Systems to automate the Kansas Nurse Aide Registry (KNAR). Automating the KNAR could allow users to enter and receive information directly from the registry, improving accessibility of the basic data and allowing the registry operator to respond to more complex calls. Users of the registry would have the convenience of accessing the registry 24 hours a day, 7 days a week compared to the current six hours a day, Monday through Friday. This proposal is in the very early stage of administrative consideration. Several other states operate automated registries. Some states have eliminated operator-assistance all together, though this is not the intent for Kansas. As this proposal wends its way through the review and approval process, the industry will be kept informed. If you have concerns, comments or suggestions, feel free to email Steve Irwin: Sirwin@kdhe.state.ks.us.

Resources for Quality Care

The following journal articles provide good information.

Gaston-Johansson, F., Johansson, F., and Johansson, N. (1999). Undertreatment of Pain in the Elderly: Causes and Prevention. *Nursing Home Medicine: The Annuals of Long-Term Care,* 7[5]:190-196.

A high percentage of elderly report experiencing acute and chronic pain. Successful pain management requires an analysis of the causes, a framework for understanding the pain, and a simple protocol to assist staff in assessing, documenting and treating pain in the elderly. This article includes strategies for improving the treatment of pain in the elderly including individuals with dementia.

Douzjian, M., Wilson, C., Shultz, M., Berger, J., Tapnia, J., and Blanton, V. (1998). A Program to Use Pain Control Medication to Reduce Psychotrophic Drug Use in Residents with Difficult Behavior. *Nursing Home Medicine: The Annuals of Long-Term Care*. Website - http://www.mmhc.com/nhm/articles/NHM9804/Douzjian.html

This article reports on an informal study using pain medication orders for 650 mg. of acetaminophen three times a day in 10 residents with difficult behaviors who were also receiving psychotrophic medication. At the end of the study, behavioral symptoms had decreased by 63% and seventy five percent of psychotrophic medications were discontinued.

ANE ISSUE STATISTICS 3/1/00 to 5/31/00
Complaint Calls Assigned for Investigation

ANE Investigations		Care Issues Investigated	
Total	401	Total	350
Mar	164	Mar	122
Apr	109	Apr	106
May	128	May	122

*Licensure Category	Civil Penalties				Correction Orders			
	2000 Quarters							
	1st	2nd	3rd	4th	1st	2nd	3rd	4th
Inadequate or inappropriate hygiene and skin care	-				2			
Inadequate or unqualified staffing	-				4			
Inoperable or inaccessible call system	-				0			
Inappropriate or unauthorized use of restraints	-				0			
Unsafe medication administration or storage	-				2			
Inadequate nursing services other skin care	-				2			
Inadequate or inappropriate asepsis technique	-				0			
Inadequate or inappropriate dietary/nutritional services	-				6			
Unsafe storage or hazardous or toxic substances	-				1			
Failure to maintain equipment	-				0			
Resident right violations	-				7			
Unsafe high water temperature	-				0			
Inadequate hot water	-				0			
General sanitation and safety	-				3			
Other (including inappropriate admission)	-				1			
Inadequate rehabilitation services	-				1			

Civil Penalties	0
Correction Orders	11
Bans on Admission	4
Denials	0

*A correction order or civil penalty may consist of multiple issues summarized within the licensure categories above.

FEDERAL REMEDIES -CATEGORIES 2 & 3 - 2000 Quarters

	1st	2nd	3rd	4th
Civil Monetary Penalties Recommended	18			
Denial of Payment for New Admissions Imposed	27			
Terminations				

I. MEASLES

All health care workers* born on or after 01/01/57 must provide adequate proof of immunity to measles with one of the following:

A. History of physician-diagnosed measles.
B. Serologic evidence of immunity.
C. Documentation of adequate vaccination.

MUMPS

All health care workers* born on or after 01/01/57 must provide adequate proof of immunity to mumps with one of the following:

A. History of physician-diagnosed mumps.
B. Serologic evidence of immunity.
C. Documentation of adequate vaccination.

RUBELLA

All health care workers* born on or after 01/01/57 must provide adequate proof of immunity to rubella with one of the following:

A. Serologic evidence of immunity.
B. Documentation of adequate vaccination.

• Adequate Vaccination

Adequate vaccination includes receipt of 2 doses of live Measles-Mumps-Rubella (MMR) vaccine at least 1 month apart on or after 12 months of age.

• Special Considerations

Adults born before 1957 can be considered immune to measles, mumps, and rubella.** However, since measles cases and related outbreaks have occurred in health care workers in this age group, health facilities should consider offering at least one dose of measles-containing vaccine to such workers who lack proof of immunity to measles.

• Serologic Screening

Serologic screening need not be done before vaccinating against measles and rubella unless the health care facility considers it cost effective. Serologic testing is not necessary for persons who have documentation of appropriate vaccination or other acceptable evidence of immunity. Testing before vaccination is appropriate only if tested persons identified as nonimmune are subsequently vaccinated in a timely manner, and should **not** be done if the return and timely vaccination of those screened cannot be ensured.

• Contraindications to Vaccination

Severe allergic reaction to a prior dose or a vaccine component
Pregnancy
Immunosuppression***
Moderate or severe acute illness
Receipt of an antibody-containing blood product

*All health-care workers (i.e., medical or nonmedical, paid or volunteer, full time or part time, student or non-student, with or without patient-care responsibilities) who work in health-care institutions (e.g., inpatient and outpatient, public and private) should be immune to measles and rubella.

**Birth before 1957 is not acceptable evidence of rubella immunity for women who can become pregnant because rubella can occur in some unvaccinated persons born before 1957 and because congenital rubella syndrome (CRS) can occur in offspring of women infected with rubella during pregnancy.

***MMR vaccination should be considered for asymptomatic HIV patients.

09/01/98

II. HEPATITIS B

The risk for acquiring hepatitis B infection from occupational exposures is dependent on the frequency of percutaneous and permucosal exposures to blood or body fluids containing blood. Any health care worker may be at high risk for hepatitis B infection depending on the tasks performed. Employees performing tasks involving exposure to blood, blood-contaminated body fluids, other body fluids, or sharps should be vaccinated. The Occupational Safety and Health Act (OSHA) Federal Standard mandates that hepatitis B vaccine be made available to all occupationally exposed health care workers.

- **Vaccination**

  Adequate vaccination for adults includes receipt of 3 doses of hepatitis B vaccine with at least 1 month between the first and second dose, at least 2 months between the second and third dose, and at least 4 months between the first and third dose.

- **Prevaccination Serologic Screening**

  Prevaccination serologic screening for previous infection is not indicated for persons being vaccinated because of occupational risk unless the health care facility considers it cost effective. The vaccine produces neither therapeutic nor adverse effects on infected persons.

- **Postvaccination Serologic Screening**

  Testing for immunity 1-2 months after completion of the vaccine series is advised for persons whose subsequent management depends on knowing their immune status, such as health care workers with blood or body fluid contact. Health care workers who do not respond to an initial vaccine series should receive an additional 3-dose series of hepatitis B vaccine with retesting performed 1-2 months after completion of the second series. If the health care worker does not respond to the second series of hepatitis B vaccine further revaccination is not indicated.

- **Duration of Immunity**

  Vaccine-induced antibodies to the hepatitis B virus decline gradually over time. Persons who initially respond to vaccination will lose detectable antibodies over a 12 year period, however studies indicate that immunity continues to prevent clinical disease. Booster doses of hepatitis B vaccine are not considered necessary, and periodic testing to monitor antibody concentrations is not recommended.

- **Contraindications to Vaccination**

  Severe allergic reaction to a prior dose or a vaccine component
  Moderate or severe acute illness

Postexposure Prophylaxis

Source of Contact→ Exposed Person ↓	HBsAg* Positive	HBsAg* Negative	Source not tested or unknown
Unvaccinated	HBIG• x 1 and initiate vaccine series	Initiate vaccine series	Initiate vaccine series
Vaccinated-known responder	No Treatment	No Treatment	No Treatment
Vaccinated-known nonresponder	HBIG• x 2 OR HBIG• x 1 and initiate revaccination	No Treatment	If know high-risk source, may treat as if source were HBsAg* positive
Vaccinated-response unknown	Test exposed person for anti-HBs:▾ 1. If adequate-no TX 2. If inadequate-HBIG• x 1 and booster	No Treatment	Test exposed person for anti-HBs:▾ 1. If adequate-no TX 2. If inadequate-initiate revaccination

*HBsAg (Hepatitis B surface antigen)
•HBIG (Hepatitis B immune globulin)
▾anti-HBs (Antibody to hepatitis B surface antigen)

III. VARICELLA

All health care workers* should be immune to varicella. Vaccination is strongly recommended for susceptible employees who have close contact with patients at high risk for serious complications from varicella infection.** Only immune personnel should care for patients suspected of having varicella. A reliable history of chickenpox is a valid measure of immunity to varicella.

• Vaccination

Adequate vaccination for individuals 13 years of age and older includes receipt of 2 doses of varicella vaccine at least 1 month apart on or after 12 months of age.

• Prevaccination Serologic Screening

Serologic screening of personnel who have a negative or uncertain history of varicella is likely to be cost effective.

• Postvaccination Serologic Screening

Routine serologic screening after vaccination with 2 doses of varicella vaccine is not considered necessary because 99% of persons become seropositive after the second dose.

• Postexposure Vaccination

Vaccination should be considered for unvaccinated health care workers who are exposed to varicella and whose immunity is not documented. However, the protective effects of postexposure vaccination are unknown. Workers vaccinated after an exposure should be managed in the manner recommended for unvaccinated persons.

• Postexposure Management

Susceptible workers exposed to varicella are potentially infective 10-21 days after exposure. They should be relieved from direct patient contact during this period and may need to be furloughed. If workers develop chickenpox, varicella lesions must be crusted before they return to direct patient contact. Receipt of varicella zoster immune globulin (VZIG) after exposure can be costly, does not necessarily prevent varicella, and may prolong the incubation period by a week or more. The period of removal from direct patient contact should be extended by one week or more if an employee receives VZIG.

• Breakthrough Infection in Health-Care Workers

Vaccination and subsequent seroconversion does not always result in full protection against disease. Breakthrough infections have occurred in vaccinees after exposure to natural varicella virus. However, vaccinees who develop varicella generally experience a milder form of disease. If a vaccinated health care worker is exposed to varicella, the following measures are recommended:

a) serologic testing for varicella antibody immediately after exposure
b) retesting 5-6 days later to determine if an anamnestic response is present
c) possible furlough or reassignment of personnel without detectable antibody

• Vaccine Virus

The risk of transmission of vaccine virus from a vaccinated person to a susceptible contact is very low. The benefits of vaccinating susceptible health care workers clearly outweigh the potential risks. Transmission of vaccine virus occurs primarily when vaccinees develop a vaccine-associated rash. Employees who develop a rash following vaccination should avoid contact with patients at high risk of serious complications from varicella infection.**

• Contraindications to Vaccination

Severe allergic reaction to a prior dose or a vaccine component
Pregnancy
Immunosuppression
Moderate or severe acute illness
Receipt of an antibody-containing blood product

*All health care workers (i.e., medical or nonmedical, paid or volunteer, full time or part time, student or non-student, with or without patient care responsibilities) who work in health care institutions (e.g., inpatient and outpatient, public and private) should be immune to varicella.
** Pregnant women, premature infants born to susceptible mothers, infants born at <28 weeks' gestation or who weigh ≤1000 grams regardless of maternal immune status, and persons immunocompromised because of immune deficiency diseases, HIV infection, leukemia, lymphoma or generalized malignancy, or immunosuppressed as a result of therapy with corticosteroids, alkylating drugs, antimetabolites, or radiation.

02/01/98

IV. INFLUENZA

Nosocomial transmission of influenza disease, including transmission from health care workers to patients, may occur during community influenza outbreaks. The transmission of influenza among health care workers often causes absenteeism and considerable disruption of health care. Influenza outbreaks may result in morbidity and mortality in patients, particularly those who reside in long-term care facilities. To reduce the spread of influenza among workers and patients, the following health care workers should be vaccinated in the fall of each year:

a) Employees who attend patients at high risk of complications* from influenza disease, whether the care is provided at home or in a health-care facility.

b) Employees aged ≥65 years of age.

c) Employees with certain chronic medical conditions (e.g., persons who have chronic disorders of the cardiovascular or pulmonary systems; persons who required medical follow-up or hospitalization within the preceding year because of chronic metabolic disease [including diabetes], renal dysfunction, hemoglobinopathies, or immunosuppression [including HIV infection]).

d) Pregnant employees** who will be in the second or third trimester of pregnancy during influenza season.

• Vaccination

Adequate vaccination for individuals 9 years of age and older is receipt of 1 dose of influenza vaccine annually. The optimal time for vaccination is October to mid-November to correspond with the peak activity period (late December to early March) for influenza. However, vaccine may be given anytime during the influenza season.

• Duration of Immunity

Immunity following influenza vaccination rarely exceeds 1 year.

• Vaccine Efficacy

Vaccine efficacy varies depending on the circulating strain and the age and underlying illnesses of the vaccine recipient. If the vaccine strain is similar to the circulating strain, 90% of healthy young adults will be protected from illness. Vaccine is only 30% to 40% effective in preventing illness among chronically-ill elderly persons. However, the vaccine is 50% to 60% effective in preventing hospitalization and 80% effective in preventing death in the elderly.

• Contraindications to Vaccination

Severe allergic reaction to a prior dose or a vaccine component***

Moderate or severe acute illness

*Patients at high-risk of complications include persons aged ≥65 years of age; residents of nursing homes and other chronic-care facilities that house persons of any age who have chronic medical conditions; adults and children who have chronic disorders of the pulmonary or cardiovascular systems, including children with asthma; adults and children who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications); children and adolescents (aged 6 months to 18 years of age) who are receiving long-term aspirin therapy and therefore might be at risk for developing Reye's syndrome after influenza; and women who will be in the second or third trimester of pregnancy during the influenza season.

** Studies suggest that pregnant women may be at increased risk for serious medical complications of influenza. Vaccination is recommended for women who will be in at least the 14th week of gestation during influenza season, generally women who become pregnant between the first of March and the first of September. No evidence exists of risk to mother or fetus when the vaccine is administered to a pregnant woman with an underlying high-risk condition.

***A history of anaphylactic hypersensitivity to egg ingestion is a contraindication to vaccination.

References

1. Centers for Disease Control and Prevention. Immunization of Health-Care Workers. Recommendations of the Advisory Committee on Immunization Practices (ACIP). Morbidity and Mortality Weekly Report. 1997;46(RR-18): 1-42.

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3. Centers for Disease Control and Prevention. Hepatitis B Virus. Recommendations of the Advisory Committee on Immunization Practices (ACIP). Morbidity and Mortality Weekly Report. 1991;40(RR-13): 1-17.

4. Centers for Disease Control and Prevention. Prevention and Control of Influenza. Recommendations of the Advisory Committee on Immunization Practices (ACIP). Morbidity and Mortality Weekly Report. 1998;47(RR-6): 1-26.

5. Centers for Disease Control and Prevention. Measles, Mumps, and Rubella Vaccine Use and Strategies for Elimination of Measles, Rubella, and Congenital Rubella Syndrome and Control of Mumps. Recommendations of the Advisory Committee on Immunization Practices (ACIP). Morbidity and Mortality Weekly Report. 1998;47(RR-8).